Grace World Outreach Church

PARENTAL CONSENT FORM

Health History

Please Print

Name _____ Age _____ Birthdate _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

School _____ Grade In or Just Completed _____

Parent(s) Business Phones _____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING? (IF YES, [x])

[ ] HEART DISEASE
[ ] ASTHMA
[ ] SEIZURES
[ ] ALLERGIES
[ ] HIGH BLOOD PRESSURE
[ ] BRONCHITIS
[ ] DIABETES

PLEASE PROVIDE ANY ADDITIONAL INFORMATION ABOUT ANY ITEMS (CHECKED YES) ABOVE:

_____

_____

_____

DATE OF LAST TETANUS BOOSTER _____ 20_____

DO YOU WEAR: (IF YES [X])

[ ] CONTACTS [ ] GLASSES [ ] DENTAL APPLIANCES

PLEASE IDENTIFY ANY PHYSICAL IMPAIRMENTS OR LIMITATIONS: _____

_____

PLEASE LIST ANY MEDICATIONS BEING TAKEN: _____

_____

IN CASE OF AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN TO RENDER TREATMENT. SHOULD THE PHYSICIAN DEEM IT NECESSARY, I AUTHORIZE HOSPITALIZATION, ANESTHESIA, SURGERY OR INJECTION OF MEDICATION.

_____ _____

SIGNATURE (PARENT IF MINOR) DATE

STATE OF FLORIDA - COUNTY OF HERNANDO

The foregoing instrument was acknowledged before me this ____ day of _____, 20 ____.

The above person is personally known to me or has shown me a photo ID verifying who they are.

_____

NOTARY PUBLIC